NORCC = ORCC X CPIAI
where:
NORCC is the new other routine cost component
ORCC is the current (base) other routine cost component
CPIAI is the CPI - All Items Economic Adjustment Factor

NAASC = AASC X W
where:
NAASC is the new Aid and Attendant Salaries Component
AASC is the current (base) Aid and Attendant Salaries Component
W is the Wage Economic Adjustment Factor

NONSC = ONSC X CPIMC
where:
NONSC is the New Other Nursing Services Component
ONSC is the current (base) Other Nursing Services Component
CPIMC is the CPI - Medical Care Economic Adjustment Factor

RATE = (FNCC + NORCC + NAASC + NONSC + FCC) X ROEF
where:
NFCC, NORCC, NAASC and NONSC are computed by formulae 1 through 4 above
ROEF is the return on Equity Factor
RATE is the new reimbursement rate per patient day for the Level of Care for the next rate year.

2) Parameters and Limitations

a) Method of Calculation

All calculations described in this methodology shall be carried out algebraically.

b) Rounding

In all calculations, the base rate and the base rate components will be rounded to the nearest one (1) cent (two decimal places) and the Economic Adjustment Factors will be rounded to four (4) decimal places.

STATE LA
DATE REC'D 9-30-96
DATE APPV'D 10-17-97
DATE EFF 7-2-96 (da) A
HCFA 179 96-34

c) Maximum Rate

The State will make payment at the statewide rate for the patient Level of Care provided or the provider's customary charge to the public, whichever is lower. If it is determined that providers have billed Medicaid at a rate in excess of the private pay rate, recoupment will be initiated.

3) Computation of Base Rate Payment

Total base rate payment rendered to a facility is comprised of a mixture of rates determined by the care needed by each resident. Each NF's total reimbursement shall be based on a mixture of client cases. Monthly reimbursement is calculated by multiplying the number of patient days for each classification of care provided by the daily rate for that Level of Care, and adding together the subtotals thus calculated to arrive at the monthly total. Such payment will be considered the total agency base rate payment for all Title XIX recipients in the facility. There is no retroactive adjustment for either over- or under-payment to the facility except as described in Section 4. for specialized services cost settlement.

b. Interim Adjustment to Rates

If an unanticipated change in conditions occurs which affects the cost of a Level of Care of at least fifty (50%) per cent of the enrolled nursing homes providing that Level of Care by an average of five (5%) per cent or more, the rate may be changed. The Bureau of Health Services Financing will determine whether or not the rates should be changed when requested to do so by ten (10%) percent or more of the enrolled nursing homes, or an organization representing at least ten (10%) per cent of the enrolled nursing homes providing the Level of Care for which the rate change is sought. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. In computing the costs, all capital expenditures will be converted to interest and depreciation. The Bureau of Health Services Financing, however, may initiate a rate change without a request to do so. Changes to the rates may be one of two types: 1) temporary adjustments or 2) base rate adjustments as described below.

STATE LA	A
DATE REC'D 9-30-96	
DATE APPV'D 10-17-97	
DATE EFF 7-2-96	
HCFA 179 96-34	

SUPERSEDES: TN. 95-01

1) Temporary Adjustments

Temporary adjustments do not affect the base rate used to calculate new rates.

a) Changes Reflected in the Economic Indices:

Temporary adjustments may be made when changes which will eventually be reflected in the economic Indices (such as a change in the minimum wage, a change in FICA or a utility rate change) occur after the end of the period covered by the Index, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

b) Lump Sum Adjustments:

Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to BHSF review and approval of costs prior to reimbursement.

2) Base Rate Adjustment - A base rate adjustment will result in a new base rate component or a new base rate component value which will be used to calculate the new rate for the next year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the Indices.

STATE LA
DATE REC'D 9-30-96
DATE APPV'D 10-17-97
DATE EFF 7-2-96 (dac)
HCFA 179 96-34

A

SUPERSEDES: TN. 95-01

TN# _____ Approval Date _____ Effective Date _____
Supersedes
TN# _____

3. Costs of Compliance with Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990

   All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

STATE Louisiana
DATE REC'D 3-29-99
DATE APP'V'D 4-21-99
DATE EFF 10-1-99
HCFA 179 99-04

A

4. Enhanced Reimbursement

a. SN/ID (Skilled Nursing/Infectious Diseases)

Reimbursement for SN/ID services shall be limited to the same rates paid for care of SN recipients plus an enhancement necessary to insure appropriate services. The enhanced amount for qualifying facilities shall be the SN patient rate plus an enhancement amount of $180.10 per diem. This amount is a negotiated CAP based on estimates of facility costs with input by specialists in treatment of this illness. Total reimbursement (SN per diem + ID enhancement per diem) shall be subject to cost settlement not to exceed the CAP.

(1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;

(2) The facility must be licensed to provide nursing services; and

(3) The facility must have entered into a contractual agreement with the Bureau to provide SN/ID services in accordance with standards for the care of individuals with infectious diseases and meet all staffing and service requirements applicable to this recipient population.

Facilities shall submit cost reports at the end of each twelve (12) month period. Providers shall be required to segregate SN/ID costs from other long term care costs in their annual cost report or submit a separate cost report for SN/ID services, which cost report(s) shall be subject to audit. No duplication of costs shall be allowed. All rates shall be subject to annual cost settlement following Medicare principles for determining allowable cost for nursing facilities. When audited cost is below the per diem limit, the Bureau shall charge back the calculated overpayment amount. No additional payment shall be made for audited costs which exceed the per diem cap.

STATE Louisiana
DATE REC'D APR 03 1996
DATE APPV'D OCT 08 1996
DATE EFF JAN 10 1995
HCFA 179 95-01
A

b. SN/TDC (Skilled Nursing/Technology Dependent Care)

Reimbursement to SN/TDC services shall be limited to the same rates paid for care of SN recipients plus an enhancement necessary to insure appropriate services. The enhanced amount for qualifying facilities shall be the SN patient rate plus an enhancement amount of $90.05 per diem. Total reimbursement (SN per diem + TDC enhancement per diem) shall be subject to cost settlement. Providers shall be required to segregate SN/TDC costs from other long term care costs in their annual cost report or submit a separate cost report for SN/TDC services. No duplication of costs shall be allowed and allowable cost shall be in accordance with Medicare cost principles.

(1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;

(2) The facility must be licensed to provide nursing services; and

(3) The facility must have entered into a contractual agreement with the Bureau to provide SN/TDC services in accordance with standards for the care of ventilator dependent recipients and meet all staffing and service requirements applicable to this recipient population.

Enhanced reimbursement in recognition of facility start-up costs associated with establishing a SN/TDC unit within an existing facility shall be allowed only to providers who meet both the SN/TDC enhancement criteria and the additional criteria outlined below. The start-up period shall be limited to two twelve (12) month periods, both subject to cost settlement and rate limits. The limit for the first 12 month period is $271.69 subject to cost settlement not to exceed the established limit. The limit for the second 12 month period is $131.75 subject to cost settlement not to exceed the established limit. Any facility which achieves a TDC census of 20 cases during the first 12 month period shall not be eligible for a second 12 month period.

- The facility must have a valid agreement with a hospital, treating TDC cases on an inpatient basis in Louisiana, to transfer 20 or more SN/TDC patients eligible for Title XIX services to the facility during the 24 month period of enhanced reimbursement;

STATE Louisiana
DATE APR 03 1996
DATE OCT 08 1996
DATE JAN 10 1995
HCFA 95-01

A

TN# 95-01 Approval Date 10/8/96 Effective Date 01/10/95
Supersedes
TN# 94-09- Attachment 4.19-B, Page 9.c.

- The facility must provide documentation and assurances from the hospital which are acceptable to the Bureau and which demonstrate that:
  - Alternative placement of SN/TDC cases in existing facilities is not feasible; and
  - 20 or more cases will be transferred to the facility during the 24 month period of enhanced reimbursement;
- The facility must provide the Bureau with a detailed operating report which projects admissions over the 24 month period, costs per month, and a total projected cost per patient day for the twelve month period; and
- At the end of each 12 month period, the facility shall file a standard long term care facility cost report which segregates SN/TDC costs from other long term care costs or a separate cost report which does not duplicate any costs attributed to other long term care services. The cost report shall be subject to review and cost settlement utilizing Medicare principles of cost reimbursement. In no instance shall cost settlement exceed the established per diem limit for the appropriate 12 month period covered by the cost report.

In no instance shall any facility be authorized to receive both SN/TDC enhancement and start-up cost reimbursement simultaneously. Facilities which qualify for start-up reimbursement shall be limited to the SN/TDC enhancement limitation following the end of the authorized start-up period.

STATE Louisiana
DATE RECD APR 03 1996
DATE APPVD OCT 08 1996
DATE EFF JAN 10 1995
HCFA ID 95-01
A

5. Neurological Rehabilitation Treatment (NRT) Program

The NRT Program services were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living which occurred within six months prior to admission.

The NRT Program has two levels of care services. The Rehabilitation level service is for an injury or condition of recent onset and the Complex Care level service is for an injury or condition requiring transitional or long term care in a specialized setting capable of addressing cognitive, medical technological and family needs.

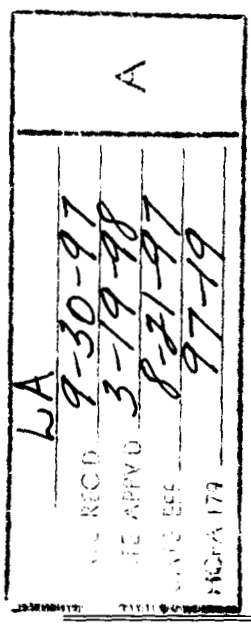
The health conditions of these patients in both levels of care must be determined to be too medically complex or demanding for a typical skilled nursing setting, but these conditions no longer warrant in-patient hospital care. The facility shall provide care to patients as outlined in the medical criteria established by the Department for both levels of care. NRT Program services should be rendered throughout the recovery process not to exceed ninety days, with a maximum of three thirty-day extensions. The NRT Level of Care certification cannot exceed a total of six months for either or a combination of both. Admissions and continued stay are determined by the Health Standards Section.

Reimbursement for NRT Program services is through prospective flat rates that were developed on budgeted cost data. The rates established are all inclusive and are not in addition to the NF rates. The Department will audit cost reports annually. The rates will be rebased when there is a minimum 5% difference in the actual rate and the audited rate.

Rehabilitation level services are designed to reduce the patient's rehabilitation and medical needs while restoring the person to an optimal level of physical, cognitive and behavioral function within the content of the person, family and community. Rehabilitation level services base rate is $489.11.

Complex Care level services are designed to provide care for patients who have a variety of medical/surgical concerns requiring a high skill level of nursing, medical and/or rehabilitation interventions to maintain medical/functional stability. Complex Care level services base rate is $359.90.

The NRT Program shall utilize the Consumer Price Index for All Urban Consumers - Southern Region, All Items Economic Adjustment Factors, as published by the United States Department of Labor to give yearly inflation adjustments. This economic adjustment factor is computed by dividing the value of the All Items index for December of the year preceding the rate year (July



SUPERSEDES: TN • 95-01

1 through June 30) by the value of the All Items index one year earlier (December of the second preceding year).

This factor, All Items, will be applied to the total base which includes fixed cost. Interim adjustments to rates shall conform to Attachment 4.19-D, Page 9., Interim Adjustment to Rates for regular nursing facilities. Rebasing shall conform to Attachment 4.19-D, Page 7.

Annual financial and compliance audits are required from the NRT Program provider as well as the submittal of additional cost reporting documents as requested by the Department.

Providers are required to segregate NRT Program costs from all other long term care costs in a separate annual cost report and submit a separate annual cost report for each level of care (rehabilitation and complex care services). Medicare cost principles found in the Provider Reimbursement Manual (HIM-15) shall be used to determine allowable costs. The facility must adhere to the following:

1) The facility must have a valid Title XIX provider agreement for provision of nursing facility services;

2) The facility must be licensed to provide nursing services and shall admit and maintain residents requiring any nursing facility level of care designation;

3) The facility must have entered into a contractual agreement with the Bureau to provide NRT Program services in accordance with standards for the care of persons with neurological rehabilitation treatment needs and meet all staffing and service requirements applicable to this client population; and

4) The facility must be accredited by the Joint Commission of accreditation of Healthcare Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF).

SUPERSEDES: TN • 95-01

STATE LA	A
DATE RECD 9-30-97	
DATE APPVD 3-19-98	
DATE EFF 8-21-97	
HCFA ID 97-19	

D. Reimbursement for State Nursing Facilities

For state institutions, reimbursement for nursing facility (NF) services shall be allowable costs based on Medicare (Title XVIII) principles of reimbursement and methods of cost apportionment contained in HIM-15 applicable to skilled nursing facilities. An interim per diem shall be established, subject to cost settlement. The interim per diem shall be equal to the Medicare (Title XVIII) SNF per diem rate for SN care, and equal to 88.89% of the Medicare (Title XVIII) SNF per diem rate for IC-I care. Medicare SNF reimbursement shall set the cap for SN care reimbursement. For IC-I care reimbursement, the cap shall be set at 88.8% of Medicare (Title XVIII) SNF reimbursement.

Lump-sum adjustments may be made when the event causing the adjustment requires a substantial capital outlay, such as a change in licensure standards mandating additional equipment or furnishings. Such adjustments shall be subject to BHSF review and approval of costs prior to reimbursement. Reimbursement methodology and amounts for lump-sum payments to public facilities shall be the same as for private facilities. See Page 9.a., Item (b) for information concerning lump-sum adjustments required to provide reimbursement for OBRA '87 costs.

Cost reports shall be filed and subject to desk review and audit by Bureau personnel or their contractual representatives. Desk reviews shall be performed on all cost reports while full-scope audits shall be performed in accordance with the criteria established for nursing facilities.

STATE Louisiana
DATE APR 0 3 1996
DATE OCT 0 8 1996
DATE JAN 10 1995
HCFA 179 95-01

A

TN# 95-01 Approval Date 10/8/96 Effective Date 01/10/95
Supersedes
TN# None-New Page